STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA RURAL HEALTH POLICY COUNCIL

PUBLIC MEETING SUMMARY
MONDAY, DECEMBER 5, 2005
1:15 p.m.

DOUBLETREE HOTEL - CAPITOL BALLROOM
2001 POINT WEST WAY
SACRAMENTO, CALIFORNIA

Reported by
Christopher Loverro

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Proceedings

Welcome – Meeting Description

Colly Tellenchach, President California State Rural Health Association: Recognizes and appreciates Rural Health Policy Council's staff participation in the conference planning.

Meeting format: Updates from the State Directors and from the Health and Human Services Agency Departments; audience is invited to provide public testimony about issues of concern.

COUNCIL CHAIRPERSON MAYBERG: The RHPC Public Meeting provides Directors, the opportunity to meet with each other; hear department update, understand programs and issues in other departments; and get feedback from all of you about issues that are particularly pressing in regard to rural health services.

Introductions

I'm Steve Mayberg, I am the Director of the Department of Mental Health, and also Chair of the Rural Health Policy Council.

COUNCIL MEMBER ARISTEIGUIETA
Good afternoon I'm Cesar Aristeiguieta and I'm the new Director of the Emergency Medical Services Authority.

COUNCIL MEMBER SHEWRY: Hello, I'm Sandra Shewry and I'm the Director of the Department of Health Services.

COUNCIL MEMBER CARLISLE: I'm David Carlisle, Director of the Office of the Statewide Health Planning and Development.

COUNCIL MEMBER STAINES: I'm Morgan Staines, Chief Counsel of the Department of Alcohol and Drug Programs, representing my Director, Kathy Jett.

COUNCIL MEMBER CUMMINGS: I'm Lesley Cummings, the Executive Director of the Managed Risk Medical Insurance Board, which runs, among other things, the Healthy Families Program.

Department Updates

Emergency Medical Services Authority (EMSA)

COUNCIL MEMBER ARISTEIGUIETA: In August 2005 I was appointed as EMSA Director. I've been spending a lot of time traveling around the State, getting to know the various EMSA constituencies.

EMSA's roles are to have an emergency pre-hospital emergency medical care network that provides all the 911 services that you expect, i.e., the paramedics showing up at your door, being able to transport you in an ambulance to the hospital, if there's a medical emergency, but we also oversee the trauma centers, the poison control system, and the medical component of a response to a disaster in the State of California. Priorities are focused around EMT and paramedic licensing and certification; emergency preparedness; trauma and hospital emergency department preparedness to the disasters.

For EMSA, rural health policy has been an issue since about 1992. I was looking at some of the maps as the shortfalls in healthcare providers and hospitals in the rural areas, and we've certainly recognized a lot of that since 1992 and continue to work towards creating an emergency medical system that meets the needs of all Californians, not just those that are in urban areas but, in rural areas as well.

EMSA has focused some funding to our seven multi-county regional EMS agencies, such as:

- Provide about $2.3 million of support annually to EMS agencies, who represent emergency medical services at the local level in 34 of the most rural counties in the State.
- Increased access to rural trauma care by steering some of the one-time, $10 million funding that the Governor gave this year for trauma care towards the rural trauma centers that we do have across the State.
- Improved paramedic access to - or patient's access to paramedic level care. In Tulare County we've recently been upgrading their EMT-2 program to full paramedic status, and that will provide a higher level of care in the pre-hospital setting for the residents of Tulare County.
- Trial studies on EMT-2 access are being conducted in Sierra and Imperial Counties. The pending EMT-2 regulation changes will provide greater limited advance life support service and availability in those counties.
- Rural AED program, automatic external defibrillators, placed in rural areas on fire department apparatus, to be to utilize that equipment for life-saving defibrillation.
- Emergency preparedness funding for personal protective equipment for hospitals and ambulances have been distributed equally to urban and rural areas.

- Poison control system funding continues to provide access to medical information following an overdose or a poisoning for folks located a significant distance from a hospital. Enables individuals on site to provide care until medical sources become available.

Department of Health Services

COUNCIL MEMBER SHEWRY:

- Hospital financing waiver: Finalizing waiver terms was a long process; the challenge of receiving federal clarification to verify the definition of a certified public expenditure (how public and UC hospitals claim Medi-Cal under the waiver) process is almost complete. Waiver totals $380M; $180M State coverage initiative, $200M federal match: funds available in years three, four and five. Waiver concept paper available, December 2005.
- Implementation of managed care in 13 of the counties, where the Legislature did agree we could expand for families, and women and children on a mandatory basis.
- Medicare Modernization Act, Part D: Start-up date: January 1, 2006 for dual eligibles (Medi-Cal/Medicare.) Duels will no longer have Medi-Cal coverage after that point Continue working with CMS and advocacy groups to emphasize need to transition to new coverage.
- Joint application for the Healthy Families and Medi-Cal programs: Proposed application completion date: Early 2006.
- Public health: Small and rural counties need core public health support. Core public support must be available for either a pandemic or bioterrorism incident, therefore the key to a good public health system.
- Minimum guidelines for every county in terms of tuberculosis (TB). 90 percent of the tuberculosis in California is in the big urban counties. Small and rural counties encompass the 10 percent that is more drug resistant than TB in the big, urban counties on average. The Communicable Disease Branch has issued guidelines for every county health department on the minimum effective program to have in place on TB.
- Cancer surveillance - Every Medical Service Study Area (MSSA) in the State will have breast cancer data. A rich database to determine environmental issues and perhaps, target interventions.
- – My Strength Program: a rape prevention program which empowers young men (14 – 18) to view their physical selves positively. Pilot Programs - Trinity and San Luis Obispo Counties have funded efforts through the high schools: expected outcomes – does message really stick with young men.
- Licensing - focusing on what resources are required to meet our minimum requirements for both federal and State law. Legislative interest.

Office of Statewide Health Planning and Development

COUNCIL MEMBER CARLISLE: Introduction of new staff: Bob David, Chief Deputy Director, formerly with the Hospital Council of Northern California and before that was an Assistant Secretary with the Health and Human Services Agency. Teresa Smanio, Assistant Director for Public Affairs and Legislation; Angela Minnifield, Deputy Director of Healthcare Workforce Community Development Division, formerly the Executive Director of the Health Professions Education Foundation; Michael Rodrian, Deputy Director of Healthcare Information Division, formerly of the Department of Health Services.

Introduction of additional OSHPD staff: Kathleen Maestas doing the administrative work and continuing the function of the Rural Health Policy Council office that OSHPD houses, as well as running our Health Policy and Data Advisory Commission; George Fribance and Gary Evans from the Cal Mortgage Program; Michael Byrne and Scott Christman, Geographic information System Specialists.

- Facilities Development Division (FDD): Basically act as the building inspector for health facilities, skilled nursing facilities, and hospitals in the State of California. We encourage you to communicate with us through our Ombudsmen line (916-653-0288), if you have any issues, any forthcoming projects that will be receiving FDD review. .
- Workforce Division: the Governor allocated $2.75 million program to train registered nurses for the State of California, in addition to the funds that are made available elsewhere in State government, this program is primarily designed to target educational facilities.

Department of Alcohol and Drug Programs

COUNCIL MEMBER STAINES: First, I want to publicly thank Carol Mordhorst for her persistence in working on an issue that affects a couple of us at this table. For many years I have been somewhat of a bystander there, as we don't really own the solution to getting some more young people into alcohol and drug treatment in Carol's county, and if she's successful, we hope that it will happen in other counties as well.

- New data gathering system- Outcomes Monitoring System. Significant new statewide data regarding the effectiveness and impact of alcohol and drug services.
- Proposition 36 funding – Governor's proposed budget update: Proposition 36: The Governor's Budget proposes to maintain General Fund support of the Substance Abuse Treatment Fund ($120 million on a one-time basis for 2006-07) to fund state and local Proposition 36-related activities. Funding for drug treatment under the voter-approved Proposition 36 sunsets June 2006, while the law allowing drug offenders to obtain treatment for drug addiction in lieu of incarceration remains in effect.
- Office of Problem Gambling – program has been in existence for some time, but not funded. Program was recently funded and housed in DADP. From a public

health perspective, is an issue that concerns many of our rural counties, as that's where many of our casinos are located. DADP has developed a prevalence study on problem and pathological gambling to determine prevention plans.

- Methamphetamines: by far the leading drug of choice for persons entering treatment in almost every county of California. About one in three persons who begin treatment in our system, methamphetamines are their drug of choice. This health issue has been observed in the Prop. 36 Program.

  Methamphetamine treatment helps users just about as well as other drug users.

  Nationally, there is discussion regarding precursor issues in making pseudoephedrine more difficult to obtain, as a prevention issue. Several states have enacted laws and, we anticipate California will be developing laws in the coming session.

  The methamphetamine issue will involve significant collaboration that will include folks at this table, and as well as others, such as, law enforcement, colleagues in the environmental resources area, and folks in public health.

Managed Risk Medical Insurance Board

COUNCIL MEMBER CUMMINGS: I'm Lesley Cummings, I'm the Executive Director of the Managed Risk Medical Insurance Board. Staff introductions: Renee Mota-Jackson, Manager in the Demonstration Projects Unit in our Benefits and Quality Management Division, and Alba Garcia, Lead Analyst on Rural Health Demonstration Projects.

- Continuing to work to cover uninsured Currently 740,000 children enrolled efforts continue to enroll eligible children. Policymakers have chosen to fund our enrollment efforts, and we're very grateful because we're getting to be a fairly costly program in terms of dollars out of people's pockets.
- Reinstatement of payments for certified application assistants: In the process of rebuilding an effective infrastructure to maximize this resource; increase of call enrollment entities (CBOs) that sign up to provide application assistance, therefore greater payments will be made application assistance. Goals of enrolling more eligible, but un-enrolled children, in Healthy Families and Medi-Cal will more likely be met through this process.
- Transition of administrative vendors has been successful. Staff has been trained, so things are going well.
- Mental Health Carve Out – three phase study in process. Phase I (funded by the Endowment) involved impacted Severe Emotional Disturbance (SED) family focus groups to determine how the carve-out of SED functions works.

  Phase II - Families' experiences in obtaining mental health services through our health plans. Plans are responsible for all services with the exception of SED services.

  Phase III - How families try to obtain substance abuse services.

- Mental Health Services: assure that Healthy Families recipients receive potential mental health services provided by Prop 63.
- Rural health demonstration projects. Procurement for last year funded 36 additional projects, ending June 30, 2007. $1.3 million was spent on seven projects that were proposed, but not funded. The remaining $1.7 million then, we went out with a solicitation for new projects (46 applications) after staff review the Board will decide on those projects in January.

Rural Health Policy Council

COUNCIL CHAIRPERSON MAYBERG: Rural Health Policy Council Office packet contains an excellent summary of what the Rural Health Policy Council has been doing since the last meeting. Resources include: workload indicators; maps about under-served areas; shortage areas; migrant and seasonal farm workers information; a variety of useful information. This exemplifies the value that the staff from the Rural Health Policy Council brings to all of us. The utilization of the internet as a mechanism to disseminate information makes sense, when we deal with issues of access, and transportation, and distance to be able to use this technology.

Department of Mental Health

Department of Mental Health - Mental Health Services Act.
Each county is in the process of doing *community planning*, meeting with their stakeholders to determine needs and issues of the unserved or under-served populations in their county. Funds were allocated for each county for facilitators or consultants assist them with the planning process. Twelve plans submitted to us, we review plans for community services and supports.

- Addressing the acute rural specialty care workforce issues with education and training funds. Collaboration with professional organizations, departments represented on this dais, and impacted counties need to address this issue.
- Small and rural counties need a coordinated focus on an efficient mental health prevention model that begins integrating care with other service providers. Counties are awaiting prevention funds to enact those programs.
- Counties have a definite need for additional outreach and engagement. Mental health services need to be provided within the community, or in places where people are in the community, not necessarily in the mental health or behavioral health clinics.
- Small and rural counties endure low incidence of particular issues, but very high cost, so it's not cost effective. Lacking an economy of scale, it's not cost effective to develop a program for those particular individuals, heavily impacting the budget, so we've been considering regional programs, in some instances.

Coordinating mental health and substance abuse programs: Director Jett and I have made a commitment to work on developing a unified response and that we have a

group called COJAC, Co-occurring Joint Advisory Committee. It's made up of county reps, providers, and State reps to look at what are the barriers that have developed to systems that really have been siloed. Through Prop. 36 we've determined that crisis care provided our least successes in the area where people have serious drug problems, and serious mental illness, that working with that population presents unique challenges in which we have to target.

Homeless population: We are aware that homelessness is not unique the urban areas. A collaborative need to be established with partners that should include Housing and Community Development, and the California Housing Finance Authority, to construct an assistance program for homeless people to get housing, ranging from rent supports to the construction of suitable units. This issue is what Prop. 63 voters noticed as a failure of our system out on the streets. Strides to access funding through a more streamline process is in the works to address this issue.

Public Comment

MS. AVRAM:

My name is Speranza Avram, the Executive Director with the Northern Sierra Rural Health Network. Today, I'm acting as the Advocacy Community Chair for the California State Rural Health Association. Thank you for joining us at our annual conference.

Review of some of the collaborative accomplishments between the RHPC and CSRHA in the past and talk a little bit about the future.

- Federal issue: RUCA- Rural Urban Community Areas. Federal government proposal to change, in fact has changed rural definitions. The State Rural Health Association, in partnership with many others, including the Rural Caucus, and many of you, advocated strongly at the federal level to change the federal definition to benefit California more equitably. Change was made at the federal level, on the definition of rural, and the result is that there are now 18 additional census tracts within California, and 85 rural communities who are now defined as rural, that were not defined before under the original definition. We thank you for your effort.
- Federal level support for rural health programs. This year, for the first time in many years, a significant number of federal rural health programs are being challenged and subjected to severe reduction or elimination. The impact on California is about $22 million for rural health programs that are currently supported at the federal level. CSRHA is working with our national association to reverse this action. We encourage the Rural Health Policy Council to write a letter to congressional appropriation leadership and urge that rural health funding be restored at the federal level.
- Over the last year CSRHA has worked particularly with OSHPD staff on the issue of gathering data through the geographical information systems, and generating data at the county level and it's been tremendously helpful for our Workforce Diversity Project. We recognized that oftentimes this data, particularly in smaller

counties, doesn't provide the detail that MSSA and zip code data does, and so we are encouraging you to keep working on that.

- Workforce is a huge priority in rural California. Focus attention on the link between healthcare facilities and the economic impact on a community. Develop a collaborative with the Policy Council, OSHPD, and the State Office of Rural Health to analyze data collection that helps us understand the economic impact of rural health workforce on rural communities, and we think that may help move the dialogue further.
- Determine existing rural health workforce programs and provide some funding to increase those programs and to increase their effectiveness.
- Noticed and appreciated the protection of rural health funding in the State budget over the past year, and we thank you for your leadership on that issue.
- Concern on managed care expansion – the new 13 counties, but even more importantly on the counties not yet targeted for expansion. Guiding principles have been submitted to the Dept of Managed Health Care around the expansion of managed care. They include protecting patient access to quality healthcare services, and insuring the financial stability of safety net providers in those counties. We encourage you to continue to consider community input and local process as the managed care expansion plan is being rolled out, and to look very carefully at future expansion.
- Executive Director for the Policy Council has been vacant since 2003. We encourage you to elevate the importance of the Rural Health Policy Council within this administration, so that we can have full time executive leadership and staff that will carry the work forward in a more comprehensive and effective manner. And we would be happy to work with you; however we can, through the Rural Caucus and the State Legislature to hire executive staff.
- Annual reports to the Legislature, about the state of rural health.

MR. BLISS:

My name is George Bliss, Physician Assistant and the Executive Director of a community clinic in Yreka, California.

Over the last six months, because of staff shortages, the County Behavioral Health Services had closed their doors to medical referrals; therefore, community clinics in Siskiyou County were forced to provide services for severely disabled and severely ill behavioral health patients. Providers, who are neither adequately trained, nor qualified to treat the severity of problems that we were being forced to see, when contacting County Behavioral Health Services, their recommendation was to send the patient to the emergency room. This impacted police departments, emergency room staff, and most of the time these people were rejected on a 51-50 evaluation, consequently putting them back on the street. This put them back in our offices and severely taxed our systems.

To compound this problem, we're now in a situation where we will not be reimbursed for behavioral health services, due to the change of CMSP to Blue Cross. We can be reimbursed for medical management, but cannot be reimbursed for LCSW case management and other types of services, which are so critically important to these patients. It seems, both State and federal level reimbursement for behavioral health services has been reduced. Medi-Care is now beginning to reject claims if there is a behavioral health diagnosis.

I realize you have no control over the Medi-Care system, but it is an omen of problems for rural health clinics because the impact of behavioral health services is increasing. Providers are asked to do depression scoring on each patient as a matter of good health care, but are not reimbursed.

I would just implore the Policy Council to keep this in mind that as we ask more of rural facilities and community health centers, that the impact of what we're being asked to do be recognized in regards to the demand on staff and financing.

MR. MOORE:

My name is John Moore of Dinuba Medical Clinic.

- My issue was brought to the RHPC four years ago, regarding hospital-based rural health clinics, absorbing rural health clinics in their area, signing two-year contracts with them and, after two years, eliminating the providers that are currently there. My clinic was a victim of this system four year ago. The process: the hospital went to the provider, told the provider that they would pay them more than I could possibly pay them, and then also said that they could assume the site if the physician could come and join the hospital. I know of two hospitals, currently in the area that are doing business in that manner.

  Apparently this practice was the result the change in the RUCA definition, where RHCs thought the new definition placed them in an urban area, so they used this practice to attempt to keep them around by creating a system where they were the only significant provider. To date, the hospitals have absorbed four non hospital based rural health clinics, that are now currently not in existence, but under the control of the hospital. Other hospitals decided that through the rural health mechanism, reimbursement was not what it was supposed to be when they were a hospital-based rural health clinic, decided to have them decertified. The main rural health clinic buys all the other rural health clinics, then compares themselves to the one that they had the highest rate, then spread that higher rate across their entire rural health system. It has caused enormous pressure on the medical providers; there are just a couple left in Kings County. There's probably one or two left in Tulare County probably none in the South County of Fresno, in the Reedley area, because of the practice that was here.

  This practice has now had an actual impact on what's going to happen in the future if, in fact, that system is allowed to continue on where the small and rural hospitals, continue to face of trying to survive the system that they're currently in,

absorb them and then, after reabsorbing them, then placing the clinic to restart over again. It's hard enough to keep providers in the area without having the providers being eliminated from the rural health setting, so that's one issue.

- Second issue: Department of Health Services' Scope of service change: The scope of service change was negotiated between the primary care association and the Department of Health Services, and they put in a 20 percent decrease for what they considered costs that they didn't want to cover. That was fine when you had a small clinic, but when you actually add a pediatrician to a rural health clinic, and you submit it to the licensing board, or the audits and investigation to say, okay, we need an increase in our rate because we've increased our service, they take that 20 percent and spread it over the three years. Well, 20 percent of adding a pediatrician, which is $180,000 a year, and you spread it over three years, and you decrease it by 20 percent each year, is about $300,000 in decreased cost. In addition, they decided that they are going to now decide to disallow costs that were currently in the PPS system, in the beginning, but now under a new audit each audit stands alone. Therefore, not only is the 20 percent decrease in affect, but then they're deciding to not cover previously covered services and, in some cases, it adds up to 35 or 40 percent. This practice does not allow the free-standing rural health clinics to do anything to increase a service that's desperately needed in the area, because no rural health clinic would ask for a 35 percent decrease. It actually would decrease the rate that they were receiving in 1985 down to levels below where they started. This makes it extremely difficult for rural health clinics to continue to do a scope of service change with that automatic 20 percent decrease right off the top.

- Third issue: Crisis and rural health medicine, in rural health areas. In six years Tulare County (South) and the Southeast County of Fresno lost one hospital, five rural health clinics, three pharmacies. In addition, the average age of area medical providers is about 60. We've got about five years to get new people to come into the area. Money is not the issue, we pay our providers very well, most of them are getting between $180,000 for medical doctors, and probably $120,000 for mid-level providers. I can't recruit them to the area. So within the next five years the rural health system in the South County of Tulare and the end of Fresno County will have a severe healthcare crisis. There will be no physicians available at that time, unless there are some significant changes in how it works.

MR. LOCKMAN:

My name is Woody Lockman, I'm the Administrator for Glenn Medical Center in Willows, California. We are a HPSA, we have two rural health clinics and we're critical access.

Issue: This is an ongoing issue as it's very difficult for our hospital, and I'm sure others, to find specialists that will come to our community or even accept Medi-Cal patients, especially ortho, neuro, and physiatry. We've been fortunate enough to have

a strong enough reimbursement rate in our rural health clinic to attract doctors to come over and do a clinic. The problem is it takes six months to get them Medi-Cal certified. Can you help us?

Response: COUNCIL MEMBER SHEWRY: I hope so. We are aware of the problem in certification and licensing of health facilities. This is the time of the year we internally review what we can propose and what we can do. We'll all know in about four weeks. The backlog on licensing visits is a real problem.

MR. FOSTER

My name is Harry Foster, I'm the President and CEO at Family Healthcare Network in the Central Valley, and Tulare County, and Kings County.

We appreciate the work Dr. Mayberg's done in our county, in regards to Prop. 63 implementation. Tulare County is concerned about the composition of our Mental Health Services Act Implementation Committee. This Committee is composed of county employees who are family members of county staff. It includes no community-based providers. The logical outcome of that would be whatever the county decided they wanted to do in Tulare County is what is being put forward. The plan was written by the staff, not by the Committee, as required by law. We say that because the Committee's met twice and prior to the plan being developed.

Except from letter from our Director of Integrated Health Services to Cheryl Dirkson, Agency Director for Mental Health in Tulare County: (letter attached to testimony)

"Although we have serious concerns with the Plan, it is with reticence that we submit this letter because our history with Tulare County officials has been that we are penalized for speaking out by loss of future contracts with the County." This not only applies to Family Healthcare Network, it applies to an entire group of mental health providers who have found themselves intimated to speak out every time they have a problem with what the County's doing. Family Healthcare Network has been involved in the Proposition 63 Mental Health Services Act, community planning process in Tulare County from the very beginning of the planning process. During this process participants, citizens, providers and community-based organizations clearly asked for a better system of care and increased access to services to include seamless and integrated physical and mental health services."

"Having reviewed the Tulare County community services and support to work plan summaries and budgets, we feel that the needs mentioned during the planning process and in the stakeholder meetings have not been addressed in the draft. We feel that effective collaboration amongst the county community-based organizations and primary care providers has not been maximized to its fullest potential to serve the county's severely mentally ill SMI population."

We're bringing this issue to the Policy Council once again because we have brought it and continue to take it to the County to no avail. The State DMH guidelines for CSS,

under strategies that are particularly appropriate for children, youth and families it states, "Onsite services and primary care clinics." For adults and older adults included under the proposed programs in the plan there is a strategy indicated for integrated physical and mental health services, which includes co-located and/or collaboration with primary care clinics or other healthcare sites and providers to provide individualized interdisciplinary coordinated services. Family Healthcare Network is already providing cultural and gendered sensitive outreach and services to racially and ethnically diverse communities, and the homeless. We provide this through our integrated behavioral health program that has been around for five years. As aforementioned, by Mr. Bliss, this mental health service has a negative impact on our nonprofit organization's sustainability, with no Medi-Cal reimbursement. We suggest that the best way to move this objective forward would be to contract with Family Healthcare Network to increase the number of individuals served in a culturally sensitive manner.

Family Healthcare Network manages a large number of patients, serving co-occurring serious mental health/physical health problems with Family Healthcare Network's multiple points of entry, providing a culturally competent staff that includes a trained licensed psychologist, and eight Ph.D. level psychologists. We offer additional access points for current county or unserved consumers to obtain necessary intervention, treatment for physical problems, case management, and/or short term medication management. Family Healthcare Network could identify, assess, triage, refer, and briefly treat individuals in an integrated environment that ensures coordinated communication between the primary care provider and the psychologist.

In the State's guiding principles for the implementation of community service and support, care must include: collaboration and integration; outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties; elimination of disparities; accessibility, and availability of mental health services; and implementation of more culturally linguistically competent assessments and services.

The county plan states proposed program collaboration that will be innovative and comprehensive. We don't feel the plan implementation will improve the fragmented system nor increase access or improve the proposed outcomes for individuals. The stakeholder process identified transportation and the lack of collaborative service providers in mental health and substance abuse treatment as health access barriers.

The Tulare County CSS plan does reference utilization of all providers and community-based organizations to assist residents who are in need of services. The plan does not specify how this assistance will occur in conjunction with the proposed plan. It has been verbally stated through many meetings that a required component of the MHSA is to contract out services to CBOs through an RFP process as mentioned in the Plan. It has not been determined as to what services will be contracted out to CBOs, or how the RFP process will occur. The Plan's approach will be to act as one-stop mental health center. Center locations will be in current Tulare County Health and Human

Service Agency Health Center Primary Care, Porterville, Visalia, and Dinuba, which currently preclude other community-based organizations to participate. The one-stop centers will not increase access to services if additional providers and necessary services are not added. Current services must interface with existing child and adult services, and not be disconnected, inaccessible, non-responsive, or inadequate. Currently many organizations are effectively providing these services. Therefore, it's imperative that the county subcontract with these organizations or agencies to provide additional services at already established locations, pursuant to expanding the access to mental health resources.

The Plan states that the mobile unit program will provide mental health services and linkages to other services for populations that are currently under-served or unserved in Tulare County. They're spending -- of the $4 million of their estimate funding allocation; they're spending a couple of million dollars on these vans. One van will literally be the mental health van that will park, and the expectation is that you'll have people come up and utilize the van's mental health services. With the stigma associated within our mental health patient population, it's just not going to happen.

We're not convinced that the Plan meets the requirements to look beyond business as usual. Its intentions are to start building a system where access will be easier, services more effective, out-of-home placements better, institutional care improved, homelessness and incarcerations reduced, and stigmas towards those who are diagnosed with serious mental illness or serious emotional disturbance reduced or minimized. We would appreciate the assistance of the Council in providing oversight. We know that we have additional oversight being provided by Darryl Steinberg, and his Mental Health Services Commission, but it does not appear to be making any change in how this is moving forward and being implemented. In our humble opinion, it's going to be squandering $4 million in our county without improving access for the mental health services.

MS. MORDHORST:

I am Carol Mordhorst, with Mendocino County.

As Morgan indicated, I am going to continue to be persistent on this issue until we get a resolution.

This morning, Sam Wilburn of DHS – Primary Care Systems Branch talked about the health information in rural areas, one of the areas mentioned was drug and alcohol problems and how significantly more these problems exist in our area.

For three or four years I have come before this group, asking that we work together to figure out how to provide drug and alcohol services to Healthy Families children. Our clinics, as well as the Public Health Department, in our case, which provides drug and alcohol services, has been unable to contract with the plans to provide needed drug and alcohol service yet the plans are not skilled or capable of providing services in our areas.

Historically, the concern has been that our drug and alcohol providers are not certified. Morgan can assert that we now are in the process of getting drug and alcohol counselors throughout the county system certified. I would ask that included in this study, that I'm delighted is happening at this time, is that we really look at what's the best way to do this. Several of you are aware of a study done in the past year that indicated that only 53 children, statewide, received drug and alcohol services under the Healthy Families program. That is disgraceful when you look at what the incidence of our youth involved in drugs and alcohol. Morgan talked about the meth problem. It's enormous in our rural counties, and we are losing children every day to this problem. Its imperative that we work together to figure out how we can deal with this problem. Solutions may include, carving it out and contracting it to counties, or requiring that the State -- of the plans contracting.

We have several models, and I know that Dr. Mayberg would indicate that the Children's System of Care is working in rural areas, the Dependency Courts are working in rural areas, the Juvenile Justice System is working in rural areas where the counties are a partner in providing services to these kids. There is no reason, no reason whatsoever that the Health Families Program can't get it figured out after all these years.

You will continue to see me here every year, but frankly, this year I have decided to take a different approach. In the past I attempted to work on this administratively, but it failed to resolve itself. Now I am asking my county to ask our Legislators to introduce legislation to address this issue, since there is no reason, when we are drug Medi-Cal certified, our employees are certified, that we cannot meet the needs of our children in rural areas. Thank you.

(Ms Mordhorst provided a copy of the proposed legislation packet to be distributed to the Council)

COUNCIL MEMBER CUMMINGS: One of the barriers that we've had, that we've long discussed here, has been the lack of certification because we contract with health plans and I, too, thought that the fact that the Department of Alcohol and Drug programs had created a method to certify substance abuse staff held promise for a solution. It's my understanding that there is a proposal that's been submitted as part of our projects for Rural Health Demonstration projects that would look this issue, to see how to work that out, that's my hope for the project.

MR. GERMANO:

My name's Dean Germano, I'm the CEO of Shasta Community Health Center, based in Redding, California, with clinics in Anderson, Happy Valley, and the City of Shasta Lake.

Follow-up written testimony provided by Dean Germano

Dear Rural Health Policy Council:

This is a follow-up to my presentation made on Monday December 5th at your meeting in Sacramento on the issue of rural California and California Children's Services. My point was primarily that some of the clinical and payment policies of CCS do not support the best interest of the children served by CCS who happen to live in the more distant rural areas of at least Northern California. As a major provider of medical care for many CCS children in Shasta County, we have run up against several CCS policies or practices that have greatly delayed care or created significant hardship to the children and/or families. I mentioned at the hearing about how hard it has been to get CCS to approve the use of telemedicine within the CCS program. While improvements in the approval of telemedicine by CCS and the enrollment process to panel physicians is a welcomed helped, there remains some significant and quite frankly costly (primarily to the State of California) policies and/or practices that can and should be corrected. While, the CCS program is a well-intentioned program and in some areas, like physical therapy, is a huge help for patients and families, the program seems to be inflexible and sometimes counterproductive to the realities of medicine in rural communities to the detriment of the CCS patient and their families. As noted in my presentation on Monday, we would like to suggest a "CCS Summit" and that we here in Redding, would host and promote that summit with senior officials of DHS and CCS to discuss potential changes in policies and practices that can both improve the care of these very fragile children and do so in a cost-effective and compassionate way. The reason to have it here in the Northstate is that in order to get busy and often overworked rural clinicians to be available to provide input one really needs to come out and visit with them. To have busy clinicians and their other representatives come to Sacramento can also work but that would greatly cut down the number of rural clinicians who could participate. With that in mind, and knowing that in the North, Redding is a medical hub, we would be happy to host and promote such a CCS policy summit. My sense from Monday's meeting, hearing from the Director of DHS, is that some kind of summit would be welcomed. I look forward to hearing from you.

Sincerely,

C. Dean Germano
CEO
Shasta CHC
Redding, CA.

COUNCIL MEMBER SHEWRY: Dean, I think that's a great idea. Probably, to get enough of our management staff's attention, we might look at a time when Rural CCS folks are coming to Sacramento and piggyback on that. But why don't you and I brainstorm about how to make that happen.

MR. PATASHNICK:

My name is Melvyn Patashnick, CEO of Sierra Kings District Hospital, in Reedley.

Issue: Unintended consequence of the Medi-Cal redesign program.

AB 915 funds are Medi-Cal supplementary funds, available for district hospitals and, I assume some government hospitals as well. Due to a federal guideline: When you have a Medi-Cal managed care patient, those expenses are not included when you calculate your eligibility for AB 915 funds.

Our hospital, for example, has been part – in Fresno County, part of a Medi-Cal managed care county for some time. When these AB 915 monies came to the State, we were told that we were going to get $1.2 million in supplemental funds, but that was including our Medi-Cal managed care expenses. Instead, we received $295,000. When the Medi-Cal redesign goes into 13 other counties, there will be district hospitals and some government hospitals that will lose large sums of money in AB 915 and supplemental dollars.

Moving managed care into rural counties is particularly difficult. Reimbursement for federally qualified health centers and rural health clinics is a set dollar amount per visit. Once a Medi-Cal managed care company comes in, they pay a reduced amount out of that set amount, a large reduced amount, then the State makes up the difference. As Medi-Cal managed care moves to rural areas, the State saves five percent, supposedly, on the costs of Medi-Cal, but then they spend all these dollars making up the difference between what the Medi-Cal managed care company pays and what's allowed to be paid for rural health clinics and federally qualified health centers.

It's frustrating to move toward Medi-Cal managed care into rural areas, especially if reimbursement glitches are not resolved. The loss of AB 915 funds, and the financial benefits I'm not sure accrue to the State in the end, anyway.

COUNCIL MEMBER SHEWRY: AB 915, is a double bind in that the federal government doesn't view a Medi-Cal managed care day as either an uninsured or a day that's not fully reimbursed, so that you can do your 915 calculations. Through the waiver, we attempted to negotiate with the feds, because this issue was raised, but uniformly they were not offering us anywhere to go on that. So that is still a legitimate concern.

On the FQHC issue I'm not sure I follow you. If a Medi-Cal fee for service member goes to an FQHC, that rate is the same whether it's fee for service or managed care. The State's obligation would be half of the value of that flat fee on the fee for service side.

MR. PATASHNICK: If you take a look at like our hospital-based rural health clinics, we have over 50,000 patient visits a year and, of course, most of them are Medi-Cal. Since we're a Medi-Cal managed care area, a large percentage of them are managed Medi-Cal, so we get a certain dollar amount per visit. Our managed Medi-Cal

companies pay a very small percentage of that dollar amount and the State Medi-Cal program, because of a suit that occurred previously, makes up the difference.

COUNCIL MEMBER SHEWRY: Right, but it's that total -- if it's -- let's say it was ten, that ten is paid to the FQHC irregardless of if it's coming from the fee for service program or managed care plus the patch. So I guess one way I've thought about it, I can see why the State, would be grumpy with that managed care plan for making -- setting it up so that we need to pay the difference. But from a hospital perspective, does that not give you somewhere to go with the plans in terms of negotiating on the fees that are paid outside of the clinic?

MR. PATASHNICK: No.

COUNCIL MEMBER SHEWRY: It should.

MR. PATASHNICK: If the fees that are paid outside of the clinic, you know, for an admission, for an outpatient service, like an ancillary service -- don't forget, a Medi-Cal managed care company comes in, they get 95 percent of what the State gets, they take their profit off the top. So for us, Medi-Cal managed care reimbursement is lower than the fee for service reimbursement. It's true; we don't lose in a clinic situation, because the State makes up the difference. My point is that one of the reasons for extending Medi-Cal managed care is to decrease healthcare costs. If you add up all of the balances that you pay for these outpatient visits, are you really saving money in rural areas by extending Medi-Cal managed care to them? If you're not, then there are other consequences like, lower reimbursement for hospitals for Medi-Cal managed care companies, because they don't have the fee for service dollars and they have to take their profit, and then the loss, at least for some district hospitals, and governmental entities, AB 915 monies, the State's not accomplishing their financial goals in terms of saving money. The hospitals are suffering in the rural areas.

COUNCIL MEMBER SHEWRY: Medi-Cal managed care, as its currently structured was never implemented with a cost-saving agenda; it was implemented with an increased access agenda.

My only comment on the FQHC hospital dynamic is there should be money there to talk to the plan about; to the extent their reimbursement for outpatient is low; then if managed care is working correctly, there should be a lessening of hospitalizations, and lessening of drug interactions. With this discussion, we can talk more about why we believe it's a preferred delivery system.

MR. SPETZLER:

My name's Herrmann Spetzler, and I work with the Open Door Community Health Centers on the Northwestern Coast of California

- The new California Center for Rural Policy was established at Humboldt State. Associate Director, Sheila Steinberg, here with us, today, and I think in the near future you'll be hearing lots of good things coming out of that group and we want you to know that it's also a resource for the State to begin to do some analysis of rural issues, in particular.

- I wanted to bring up today was a law that was passed in, oh, I think '02, and came into effect in January '03, and it has to do with phlebotomy certification in labs that are in doctors' offices, community clinics, in smaller labs. After the initial phase in period, the drop dead date will be April 2006. Unfortunately, the State that has not been able to meet its deadlines, I think that many, many rural providers are not aware of the fact that they will no longer be able to have blood draws happening in their facilities. The process of getting licensed is 40 hours didactic and 40 hours of practical. There are very few places in the State that are doing the teaching at the moment, so that when you really get rural or frontier even, finding a place where you can get your staff licensed is difficult. The practical is also 40 hours and it's interesting because within those 40 hours you have to take 50 specimens, and it's not just 50 specimens, there have to be ten dermal sticks, and then there has to be a variety of ages, and a variety of obesity levels, and acuity levels, and the like. Getting the critical mass to do this – not realistic. You know, it's a little bit like the nursing dilemma that we have in the State, where we legislatively make decisions about resources that don't exist. Here we've done the same thing, we've made rules and we're implementing rules that will force staff who hasn't had the time to implement this. It costs about a thousand dollars to do it. There are six places in the State within which the test can be taken. My clinics, for instance, the closest place is in Redding. Redding takes a very limited number of out-of-areas, out-of-Redding-area folks for the training. It's a three-hour roundtrip. The worst part about it all is that these are folks that tend to make 12 to 14 dollars an hour. We're not talking about mid-level practitioners; we're talking about medical assistants in a rural area that are doing a particular function.

  I just wanted to bring it up as a heads up issue. I think reality dictates, both on the workload on the State side, and the ability for us to train our staff that we will not make it by April 2006, and I think rural providers don't want to be out of compliance. Thank you.

MS. WEIST:

I'm Linda Weist, Director of Clinics from Mark Twain St. Joseph Hospital.

I have several phlebotomists who have passed the exam and waiting for certification. My question is: Can they go ahead and practice while we wait for that piece of paperwork?

COUNCIL MEMBER SHEWRY: I don't know the answer to that. Call me.

COUNCIL CHAIRPERSON MAYBERG: I just want to say, I'm always amazed at how new issues evolve, and the thoughtfulness of how you present the topics, we hardly had any of the old topics, all these are new. I think it's great and it probably says a lot about how sophisticated we all are in understanding it.

COUNCIL MEMBER STAINES: I'm going to have to slip out, I've got another meeting calling to me urgently, but my colleague, Les Johnson, is here, who's our Director of Constituent Development. He will be available for questions after the session. Again, I thank you for welcoming me.
COUNCIL MEMBER CUMMINGS: I have an additional department update: Development of a Healthy Kids buy-in to the Healthy Families Program.

There are localities that are interested in purchasing coverage for children that are not eligible for Healthy Families or Medi-Cal. These localities have generally created programs at their county level to provide services, and they're called Healthy Kids services. We were approached by several rural counties that were very interested in doing that, but did not feel that they had the wherewithal to do planned contracting and contract with an administrative vendor for collection of premium, et cetera. So, we are in the process of trying to develop such a program. Target date: July 2006. We have letters of interest from about 11 rural counties.

MR. ABBOTT:

Hi, my name is Peter Abbott; I'm retired from the Department of Health Services.

There's a lot of talk about the Governor and the Administration coming forward with a major infrastructure bond approach. In terms of rural health infrastructure, is there any chance that there will be a rural component and a health component as part of this proposal?

COUNCIL CHAIRPERSON MAYBERG: There certainly is interest, both in the Legislature and in the Administration, at infrastructure issues, and to look at how we revitalize some of our aging infrastructure. Upon the release of the budget in January we'll get a better sense, of will occur between the Legislature and the Administration. All of the state has aging needs.

On behalf of all of us here, we were just commenting, this is probably the best attendance we've had, we love it like this. That the questions are fresh and you've pushed us to think a little bit more and thank you very much for inviting us to have time with you at your conference.

Meeting adjourned: 3:00 p.m.

CERTIFICATE OF REPORTER

I, CHRISTOPHER LOVERRO, an Electronic Reporter, do hereby certify:

That I am a disinterested person herein; that the foregoing State of California, Health and Human Services Agency, California Rural Health Policy Council meeting was reported by me and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties in this matter, nor in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 20th day of December, 2005

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